VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

August 19, 2011

Ms. Meagan Buckley, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641

Provider ID#: 475020

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on July 20, 2011. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

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Division of
AUG 17 11
Licensing and Protection

PRINTED: 08/04/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
~~CENTERS FOR MEDICARE & MEDICAID SERVICES~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. BUILDING _____ B. WING _____	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN HEALTH & REHAB CTR	98 HOSPITALITY DRIVE BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and complaint investigation were conducted by the Division of Licensing and Protection from 7/18/11 to 7/20/11. The following regulatory deficiencies were cited.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of the medical record, the facility failed to honor the food preferences and medical food restrictions of 1 of 17 residents in the Stage II sample (Resident #183). Findings include: On 7/18/11 at 2:05 PM during the Stage I resident screening interview, Resident #183 indicated that s/he does not receive the food s/he prefers on his/her meal tray and that his/her dietary restrictions are not honored. Per observation of the meal service at 5:00 PM on 7/18/11, Resident #183's tray contained a ham salad sandwich on white bread, mashed potatoes, tomato soup, a cookie, coffee, creamer, sugar, a packet of ketchup, tea and a mighty shake. The dietary tag on the residents tray indicated the tray contained	F 242	Corrective action: F 242 1. Resident #183 evaluated and no negative outcome resulted from this alleged deficient practice. 2. Meal tray ticket error was corrected and dietary preferences reviewed and updated on care plan. 3. All residents with special diets and allergies are at risk. 4. Dietary to ensure special restrictions and allergies are identified and followed. 5. Re-educate dietary staff on diet tray card accuracy. 6. Random weekly audits to be performed by Dietary Manager or designee to determine continued compliance with plan. 7. Dietary Manager shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. 8. Corrective actions shall be complete by 8/20/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Breer | TITLE: Administrator | (X6) DATE: 8/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	Continued From page 1 a cheeseburger, french fries, chicken noodle soup, tea, sugar, ketchup, a cookie and a mighty shake. The dietary tag also indicated that the resident likes whole wheat bread, fruit and cottage cheese and also indicated that the resident was not to have any tomato products. Review of the medical record indicated that Resident #183 has medical diagnoses of recent surgical repair of a hiatal hernia and GERD (gastroesophageal reflux disease). Review of the nutritional care plan dated 5/23/11, Resident #183 has allergies to tomatoes and pineapple. On 7/18/11 at 5:30 PM, during interview with the Dietary Service Manager (DSM) and the Registered Dietician (RD), they had changed the menu and substituted tomato soup for the chicken noodle. The RD indicated that the ham salad sandwich and the mashed potatoes where utilized for Resident #183 due to a diet consistency of mechanical soft. The DSM indicated that the line servers had not read the ticket when placing the items on Resident #183's tray. The RD, DSM and the District Manager confirmed the potential for allergic reactions and medical issues from not adhering to the residents dietary restrictions was of concern.	F 242	F242 POC accepted 8/18/11 Karen Campos RN	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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F 279	Continued From page 2 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that a comprehensive care plan was developed to address all identified needs for 1 of 17 residents in the stage 2 sample. (Resident #129) Findings include: Per record review on 07/19/11, Resident #129's chart had an initial interim care plan dated 06/27/11 that listed general categories of care but not individualized approaches for the resident regarding preferences/needs for dressing and for grooming (assistance with shaving) and to have family member present for physician visits. The comprehensive assessment was completed on 07/07/11 which identified the resident's objectives for the highest level of functioning, likes and dislikes, such as family notification and dressing. Per observation during the 3 days of survey the resident was noted to have only a johnny shirt (hospital gown) and was unshaven. Per interview	F 279	Corrective action: F 279 1. Resident #129 evaluated and continues to prefer to wear a "jonny" at times and refuses assistance with self care elements, no negative outcome resulted from this alleged deficient practice. 2. Comprehensive care plan was completed on 7/19/2011. 3. All residents needing a comprehensives care plan are at risk. 4. Nursing department to ensure comprehensive care plans are completed timely by 8/20/2010. 5. Re-Educate unit managers regarding completion of comprehensive care plans. 6. Random weekly audits to be performed by Director of Nursing or designee to determine continued compliance with plan. 7. Director of Nursing or designee shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. 8. Corrective actions shall be complete by 8/20/2011 F279 POC accepted 8/18/11 Karen Campo RN	

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F 279	Continued From page 3 on 07/19/11 at 3:45 PM, a family member stated, "I was never told that I should bring in clothes until yesterday but I didn't know I needed to, [Resident #129] never went to the doctors or anywhere that much so I wasn't sure what to do". The family member was also upset that staff did not alert her that [Resident #129] was going to the urologist yesterday and that s/he was afraid. Per interview at 4:10 PM on 07/19/11, the resident stated "I don't want to be a burden, but it would be o.k. to have a shave and to get a shirt on sometime, I just don't know how things work here". The resident also stated that "I would really like it if my daughter comes with me to the doctors and I told them that when I got here". Per interview on 07/19/11 at 4:30 PM the Unit Nurse confirmed that the comprehensive care plan was not completed to address all identified needs.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to meet professional standards of quality regarding administration of expired medications or obtaining, following, and documenting physician orders for 2 of 17 residents in the Stage 2 sample (Residents #8, #56). Findings include: 1. Per record review of the MAR (Medication Administration Record) for Resident #56, Nephro-Vit is written as to be given at 8:00 PM, however a physician order was written to be given	F 281		

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F 281	Continued From page 4 at 8:00 PM. Per interview on 07/20/11 at 3:00 PM, the staff nurse stated that the medication was changed "because the resident requested it" and confirmed that the physician was not notified of the time change for this medication. In addition, Colace 100 mg (milligrams), Ranexa 500 mg ER (extended release), and Morphine Sulfate ER were changed from 5:00 PM to 8:00 PM. The Unit Manager confirmed on 07/20/11 at 3:35 PM that there are no orders for the time changes for administration of these medications. 2. Per observation, interview, and record review, Resident #8 received medication (an antibiotic)that was expired and staff failed to document administration of 2 doses of that antibiotic. Physician orders written for Resident # 8 included "Vancomycin [antibiotic] 5 milliliters [125 milligrams] PO [by mouth] daily until 6/20/11, every other day for 14 days, then every 3 days for 14 days, then once weekly for 14 days, then discontinue." Per observation of the medication storage room on 'A wing', both bottles of liquid vancomycin labeled for Resident #8 were expired, with expiration dates of 6/19/11 and 6/24/11. Per interview on 7/20/11 at 2:45 PM, the Unit Manager confirmed that both bottles were past their expiration date. Resident #8 received multiple doses of the medication after the dates of expiration. Per review of the Medication Administration Record (MAR), doses due on 7/8/11 and 7/17/11 were not documented as being administered. Per interview on 7/20/11 at 2:45 PM, the Unit Manager [UM] confirmed that the doses due per physician's order on 7/8/11 and 7/17/11 were not initialed as given on the MAR.	F 281	Corrective action: F 281 1. Resident #8 and #56 were evaluated no negative outcome resulted from this alleged deficient practice. 2. Resident #56 physician was contacted and order received to administer medications at revised times per resident request. Resident #8 medication was discarded immediately. 3. All residents receiving medications and those residents receiving medications that require refrigeration are at risk. 4. Re-educate licensed nurses regarding proper administration of medications and obtaining physician orders. 5. Random weekly audits to be performed by Director of Nursing or designee to determine continued compliance with plan. 6. Director of Nursing or designee shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. 7. Corrective actions shall be complete by 8/20/2011 F281 POC accepted 8/18/11 Karen Campos RN	

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F 281	Continued From page 5 References: 1. Lippincott, Williams & Wilkins. Nursing 2010 Drug Handbook, pg 13-18. 2. Lippincott Manual of Nursing Practice (9th ed.), Wolters Kluwer Health/Lippincott Williams & Wilkins, pg 17.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide services according to the care plan for 2 of 17 residents in the Stage 2 sample (Residents #92, #183) Findings include: 1. Per observations on 07/19/11 and 07/20/11, Resident #92 remained in a geri-chair without being repositioned or toileted for greater than 3 hours. Per continuous observation on 07/19/11 from 9:15 AM until 12:15 PM, the resident was observed in the same position with the legs up at 45 degrees, and with a pillow on the right side, in the hallway near the main dining room. Staff did not offer to reposition or toilet the resident prior to or after the meal. Per observation on 07/20/11 from 9:15 AM -11:15 AM, Resident #92 was in the geri-chair with legs elevated. Per record review, the care plan dated 5/10/11 for ADL/FUNCTIONAL states that in addition to the	F 282	Corrective action: F 282 1. Resident #92 and #183 were evaluated no negative outcome resulted from this alleged deficient practice. 2. Resident #92 care plan was adjusted to meet the resident's needs. Resident #183 meal tray ticket error was corrected and dietary preferences reviewed and updated on care plan. 3. All residents requiring assistance with repositioning and nutritional preferences/special diets/allergies are at risk. 4. Re-educate licensed nurses regarding monitoring expiration dates of all medications. Re-educate dietary staff on diet tray card accuracy. 5. Random weekly audits to be performed by Director of Nursing and Dietary Manager or designee to determine continued compliance with plan. 6. Director of Nursing and Dietary Manager or designee shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. 7. Corrective actions shall be complete by 8/20/2011	

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F 282	Continued From page 6 resident requiring extensive assist for bed mobility and requiring a mechanical lift for transfers, Resident #92 is to be checked and changed before and after meals (incontinence care). Per the LNA (Licensed Nursing Assistant) list care plan, Resident #92 is to be repositioned every 2 hours and states to offer a urinal or to check and change before and after meals Per interview on 07/20/11 at 2:00 PM the LNA stated "I got [Resident #92] up around 7-ish, washed, served breakfast, sat in chair near nursing station, and then out in hallway near dining room, and just now did the incontinence care". S/he confirmed that on 7/20/11 Resident #92 was not repositioned for greater than two hours, nor checked and changed before and after meals. The Unit Manager at 2:15 PM on 07/20/11 confirmed that care and services were not provided as care planned for this resident. 2. Per record review on 7/18/11 of the nutritional care plan dated 5/23/11, Resident #183 has allergies to tomatoes and pineapple. Review of the medical record indicated that Resident #183 has medical diagnoses of recent surgical repair of a hiatal hernia and GERD (gastro esophageal reflux disease). Per observation of the meal service at 5:00 PM on 7/18/11, Resident #183's tray contained a ham salad sandwich on white bread and tomato soup. Per interview on 7/18/11, Resident #183 indicated that s/he was not to have tomato soup per physician's instructions. Per review of the dietary slip on the tray, it indicated that Resident #183 likes whole wheat bread, cottage cheese and fruit and is not to have tomato products.	F 282		

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F 282	Continued From page 7 On 7/18/11 at 6:30 PM, during interview with the Dietary Service Manager (DSM) and the Registered Dietician (RD), they had changed the menu and substituted tomato soup for the chicken noodle. The DSM indicated that the line servers had not read the ticket when placing the items on Resident #183's tray. The RD, DSM and the District Manager confirmed the potential for allergic reactions and medical issues from not adhering to the resident's dietary restrictions was of concern.	F 282	F282 POC accepted 8/18/11 Karen Campo RN	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services to ensure each resident maintains the highest practicable physical well-being for 1 applicable resident in the sample regarding the avoidable worsening of a wound. (Resident #193) Findings include: 1. Per record review, Resident #193 was admitted on 7/1/11 with a scabbed area on his/her left ankle. The only documented "assessment" of this wound was a circled left ankle on a body diagram, an indication that it was	F 309		

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F 309	Continued From page 8 a scab, and a measurement of 0.7 cm (centimeters). There was no documented assessment as to what the underlying cause of the wound was, whether is was pressure related, related to an impairment in circulation, or other cause. There was no documented assessment regarding the wound edges, shape, or condition of surrounding tissues on admission. Per review of the Treatment Administration Record (TAR), there was no documentation of any treatment to the left ankle wound for a period of 12 days after admission. On the TAR, licensed staff indicated "intact skin" on 2 occasions during the same time frame of 13 days since admission, when there were 2 additional wounds other than the left ankle wound that the resident was receiving documented treatments for. The first nurses' note regarding the left ankle wound, dated 7/12/11 indicated the skin surrounding the hard scabbed area on the left ankle is pink and tender to touch. A skin condition report, dated 7/13/11 indicated the left ankle wound measures 1 cm by 1.2 cm (an increase in size since admission), there was presence of slough (a layer or mass of dead tissue separated from surrounding living tissue) in the wound bed, and there was redness around the edges. A wound nurse consult, dated 7/14/11 indicated that the left ankle wound was "covered with slough", "tender when palpated", "wound border is red", and recommended a physician consult. The wound nurse also indicated that Resident #193 had no palpable pulses in his/her feet and the feet were cold. The physician consult recommended on 7/14/11 was not ordered until 7/19/11. Nurses' notes on 7/17/11 indicate the left ankle wound to be crater like,	F 309	Corrective action: F 309 1. Resident #193 was assessed and no negative outcomes from this alleged deficient practice. 2. Resident #193 was assessed on 7/14/11 by Certified Wound Ostomy Nurse and faxed requested to physician on 7/14 and 7/15 for further vascular consult. On 7/19/11 the physician requested that we discuss with family first, on 7/20 family was consulted and declined interventions. On 7/21/11 Resident #193 was assessed by Certified Wound Ostomy Nurse and noted improvement of wound. Physician assessed resident #193 again on 7/25/11. 3. All residents with ulcers are at risk. 4. Re-educate licensed nurses regarding ulcer assessment. 5. Random weekly audits to be performed by Director of Nursing and or designee to determine continued compliance with plan. 6. Director of Nursing or designee shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. 7. Corrective actions shall be complete by 8/20/2011	

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F 309	Continued From page 9 deep redness surrounding the area, the wound bed has yellow green slough in the center, and the resident voiced tenderness during the dressing change. During interview on 7/20/11 at 9:30 AM, the Unit Manager confirmed that the left ankle wound had deteriorated in the period from admission to the wound consult on 7/14/11, nurses documented skin as intact on the TAR while the resident had open wounds, and confirmed that the physician consult was not ordered until 5 days after the recommendation was made by the wound nurse. During interview on 7/20/11 at 11:06 AM, the Director Of Nursing confirmed that Resident #193 was not seen on weekly interdisciplinary wound rounds until 7/14/11, and confirmed that the Resident was admitted with open wounds.	F 309	F309 POC accepted 8/18/11 Karen Campoz RN	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that dietary staff stored, prepared, and served foods under sanitary conditions in accordance with acceptable safe	F 371		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN HEALTH & REHAB CTR	98 HOSPITALITY DRIVE BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10 food handling practices. Findings include: 1. Per observation in the kitchen during the initial tour on 7/18/11 at 10:10 AM, the following areas/practices were noted: a. Per observation of the 3 bay manual dishwashing sink, several pans were in water in the second compartment and per interview with the Food Service Manager on 7/18/11 at 10:10 AM, the pans had been soaking since 5:45 AM. When tested by the Food Service Manager (FSM) for adequate amounts of sanitizer in the water, the litmus test revealed the water did not contain enough sanitizer to be read on the litmus test. The Food Service Manager confirmed the reading, and the sink was drained and the sanitation process restarted. b. Per observation of the dry goods storage area, a large gallon container of Cesar salad dressing was observed to be opened and sitting on the shelf and not under refrigeration. The FSM confirmed that the salad dressing should be kept refrigerated after opening. c. Per observation, eight pieces of unlabeled frosted cake were stored on the metal rack in the kitchen. The FSM confirmed they were not dated and were to be disposed of today. d. Per observation, the hot steam table contained water and food debris (rice) in the bottom and the water had a "rusty" appearance to it. A food service cook indicated that the steam table was turned on at 5:30 AM and it was to be drained and sanitized nightly. The FSM confirmed at 10:30 AM that the "rice" was from the dinner	F 371	Corrective action: F 371 1. Issues identified on kitchen tour and dining observations resulted in no negative outcomes from this alleged deficient practice. 2. Item A, dish sink was drained and sanitation process was restarted immediately on 7/18/11. Item B was disposed of immediately on 7/18/11. Item C were disposed of on 7/18/11. Item D, steam table was cleaned and refilled on 7/18/11. Item E was disposed on 7/18/11. Staffs observed in the dining room were re-educated immediately on hand washing. 3. All residents that consume meals at the center are at risk. 4. Re-educate dietary staff on proper storage, preparation and service of food under sanitary conditions. Re-educate staff assisting in the dining room about proper hand washing. 5. Random weekly audits to be performed by Director of Nursing and Dietary Manager or designee to determine continued compliance with plan. 6. Director of Nursing and Dietary Manager or designee shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. 7. Corrective actions shall be complete by 8/20/2011	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 371	Continued From page 11 service the day before and that the steam table had not been cleaned. e. Per observation of the walk in cooler, a 10 pound bag of moldy red onions was found on the cooler floor. The FSM confirmed the onions were moldy and removed them from the cooler. 2. Per observation in the Main Dining Room on 7/18/11 at 4:00 PM the following areas/practices were noted: a. Per observation, a Food Server was observed to utilize his/her gloved hands to handle tray tickets from the counter, handle condiment packages and retrieve a knife from a drawer and then utilize the same gloves to pick up a grilled cheese sandwich and place it on a residents plate. The FSM confirmed at 4:22 PM, after observing the food server, that the food server had utilized gloved hands to handle non- food items and then did not change the gloves before handling and placing a consumable item on a resident's plate. b. Per observation in the main dining room on 7/18/11, Staff #1 was observed feeding two residents and was helping with hand held foods, touching residents hands and shoulders and assisting with tableware and food dropped by the residents. During this time s/he did not glove or sanitize her hands. During interview at 4:45 PM, the staff member stated that s/he would normally sanitize hands between resident contacts but didn't have any sanitizer at the table.	F 371	F371 POC accepted 8/18/11 Karen Campos RN	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 12 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications	F 431	Corrective action: F431 1. Resident #8 was assessed and no negative outcomes from this alleged deficient practice. 2. Resident #8 medication was immediately discarded. 3. All residents that receive medications that require refrigeration are at risk. 4. Re-educate licensed nurses regarding proper administration of medications. 5. Random weekly audits to be performed by Director of Nursing and or designee to determine continued compliance with plan. 6. Director of Nursing or designee shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. 7. Corrective actions shall be complete by 8/20/2011 FH31 POC accepted 8/18/11 Karen Campos RN	

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F 431	Continued From page 13 were discarded after the expiration dates for 1 of 17 residents in the Stage 2 sample (Resident #8). Findings include: 1. Per observation on 7/20/11 at 2:00 P.M. the medication refrigerator located on 'A wing' of the facility contained one 80 ml. (milliliter) bottle of Vancomycin (antibiotic) for Resident #8 with the expiration date of 6/19/11, and one 200 ml. bottle of Vancomycin for Resident #8 with the expiration date of 6/24/11. Per review of Resident #8' s Medication Administration Record [MAR], the resident was scheduled for the Vancomycin to be given every 3 days for the past 2 weeks, and was now to receive it once weekly for 2 weeks. Per interview on 7/20/11 at 2:45 PM, the A wing Unit Manager (UM) confirmed that both bottles of Vancomycin were in use past their expiration dates.	F 431		

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